

**Part D Questions re:  
Co-pays for Institutionalized Individuals  
April 19, 2006**

**Question 1.** We understand that LTC residents who are dual eligibles must reside in a LTC facility for one full calendar month before they qualify for the \$0 co-pays. What happens when the resident is admitted to the nursing home, goes back into the hospital as an inpatient, and then is readmitted to the nursing home? Do the hospital stay and the readmission start the calendar month calculation over?

**Response:** The term “institutionalized” for the purpose of a Part D plan applying a zero co-pay refers to a full benefit dual eligible (an individual who has Medicare and full Medicaid benefits) who is an inpatient in a medical institution or nursing facility for which Medicaid made payment throughout a calendar month. Except for a first partial month of admission, it is generally not known whether or not the individual will be in the institution throughout the entire month, or whether Medicaid will pay throughout the month, until after the entire month has elapsed and the facility submits a claim to Medicaid. However, the co-pay determination must be made in real time at the point of sale, prior to complete information regarding institutionalization and Medicaid payment being known; therefore the following assumptions must be made in order to implement this policy.

In the first partial month of admission (i.e. when an individual is admitted on any day other than the first of the month, from a community setting to a medical institution for the remainder of the month) the individual is not considered institutionalized for part D purposes. Effective the first day of the following month, if the individual is expected to remain throughout the month, assume the co-pay should be at the institutional level of \$0. Institutional status is not interrupted by transfers between medical facilities or by bed hold days. Institutional status is only interrupted by a discharge to a community setting such as the home or assisted living. Operationally, if the institutionalized individual remains Medicaid eligible, the individual’s co-pay will remain at \$0 throughout the remainder of calendar year 2006.

**Question 2.** During the interim period when a new nursing home admission -- who is dual eligible -- is waiting to meet their one calendar month requirement for \$0 co-pays, is the facility ever responsible for paying the co-pays? Should the \$1 & \$3 co-pays be charged to the resident and deducted out of the Personal Needs Allowance (PNA) (as long as it meets State regulations) or paid for by private funds? If there is not enough money, no family, or the resident refuses to pay, can the LTC pharmacy ever charge the nursing home for the co-pays?

**Response:**

A Medicare skilled nursing facility (SNF) must ensure that residents obtain needed Part D drugs and may determine that it needs to pay Part D copayments in some instances to fulfill that obligation. Such costs are not separately billable to Medicare Part A or B but a SNF may charge the resident for these costs.

In a month in which co-pays are charged to the resident, these costs are the resident's liability. Under Medicaid, these costs are treated as a deduction from income when calculating the individual's contribution to the cost of institutional care, as are other medical and remedial services that remain the individual's responsibility. This deduction reduces the amount of income the resident is considered to have available to contribute toward the facility rate, and allows the resident to retain an amount necessary to satisfy the copayment liability. Because the available income to contribute toward the facility rate is less, the State payment under Medicaid to the facility will increase by the amount of the deduction. By contrast the PNA is a separate deduction for incidental or personal expenses, and is not for medical expenses such as co-pays. If the individual has insufficient income to cover the full cost of the co-pays in a given month, the difference may be carried over to the following month(s) until the liability is satisfied.

Under either Medicare or Medicaid, a long term care facility is not responsible for paying the pharmacy for a beneficiary obligation (e.g., copay, coinsurance, etc.) unless the facility has assumed this obligation by contract or such payment is required by state law.

It is important to make a distinction between payment of cost sharing and the delivery of drugs that are medically necessary. Under 42 CFR 483.60, a facility (either skilled nursing facility or nursing facility) must "provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.75(h)." A facility may charge the resident for these costs.